STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) I		(X3) DATE	SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITH DING		00	COMPL	ETED
		155573	A. BUILDING B. WING			05/26/2	011
		<u> </u>		FET AI	DDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUPPLIEF	₹	I		ECHWOOD AVENUE		
MILLER'S	MILLER'S MERRY MANOR				TOWN, IN47356		
					10000, 11047330		
(X4) ID		STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PERCEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ГЕ	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	<u> </u>	DEFICIENCY)		DATE
F0000							
		-		ŀ	The feelite was a still a subse	:4-	
		or a Recertification and	F0000		The facility respectfully submethe following plan of correction		
	State Licensure	Survey.			our credible allegation of	JII as	
					compliance for the following		
	Survey dates: M	ay 23, 24, 25, & 26, 2011			deficiencies. We request a p	aper	
	•				compliance of the deficiencie		
	Facility number:	000342					
	Provider number						
	AIM number: 1						
	Alivi liullioci.	100289140					
	Survey team:						
	Angel Tomlinson						
	Leslie Parrett RN	N					
	Sharon Lasher R	² N					
	Barbara Gray RI	N [May 23, 2011]					
	Census bed type						
	SNF: 8	•					
	SNF/NF: 30						
	Total: 38						
	Census payor typ	pe:					
	Medicare: 8						
	Medicaid: 24						
	Other: 6						
	Total: 38						
	Sample: 10						
	Sample. 10						
	The second of the second	an also mellest at it.					
		es also reflect state					
	_	accordance with 410 IAC					
	16.2.						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

LYYY11

Facility ID:

000342

If continuation sheet

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
		155573	B. WING			05/26/20	011
NAME OF B	DOWNER OF CLIPPLIER		1		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			981 BE	ECHWOOD AVENUE		
MILLER'S	S MERRY MANOR			MIDDLE	ETOWN, IN47356		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	Έ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	1	TAG	DEFICIENCY)		DATE
		ompleted 6/3/11 by					
	Jennie Bartelt, R	N.					
F0223	The resident has t	he right to be free from					
SS=A		sical, and mental abuse,					
		ent, and involuntary					
	seclusion.						
	The facility must n	ot use verbal, mental,					
	sexual, or physical						
	punishment, or inv	oluntary seclusion.					
	Based on intervie	ew and record review, the	F0	223	Residents #4 and #10 still re	side	06/25/2011
	facility failed to j	prevent a staff member			in the facility and have experienced no negative		
	from forcing 2 re	sidents to take			outcomes from this incident.	_{АП}	
	medication when	the residents refused for			interview able residents were		
	2 of 2 residents s	ampled for abuse in total			questioned as part of the init		
	sample of 10 (Re	sident #10 and Resident			investigation to ensure no otl		
	#4).				residents were affected by the practice. The employee was		
					immediately removed from th		
	Findings include	:			facility while an investigation	into	
					the incident was completed.	The	
	1. Review of the	record of Resident #10			employee was terminated following the completion of the	16	
	on 5-23-11 at 10:	40 a.m., indicated the			investigation.On 6/22/11 all s		
	resident's diagnos	ses included, but were			will be re-in serviced on facili	ty's	
	not limited to, va				abuse policies and procedure		
		ssion and anxiety.			including recognizing abuse abuse prevention and reporti		
		-			[Attachment #1].This process	- 1	
	The Minimum D	ata Set (MDS)			be monitored monthly by all		
		d 5-23-11, for Resident			managers through the Guard		
		e following: makes self			Angel rounds using the Qual		
		illy understood and			Assessment "Abuse and Neg Review" form. [Attachment #		
		and others- usually			Any concerns will be reported		
	understands.				immediately to the administra	ator	
					or DON. The review forms w	ill be	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

LYYY11

Facility ID:

000342

If continuation sheet

Page 2 of 28

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPL	ETED
		155573	B. WIN			05/26/2	011
		1	P. 1121		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	8		1	ECHWOOD AVENUE		
MILLER'	S MERRY MANOR			1	ETOWN, IN47356		
(X4) ID	I SUMMARY S	STATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	DATE
	2. Review of the	record of Resident #4 on			reviewed at the monthly Qua	lity	
		a.m., indicated the			Assessment meeting for six		
	1	ses included, but were			months and then quarterly		
	1	enile dementia with			thereafter for six months.		
	depressive featur						
	depression.	ies, anxiety and					
	depression.						
	The MDS dated	4-11-11, for Resident #4					
	1	lowing: makes self					
		•					
		erstood and ability to					
	understand other	rs- usually understands.					
		A 1					
		ne Administrator on					
	1	o.m., indicated she					
		N#4 about allegations of					
	abuse on 5-6-11.	The Administrator					
	indicated LPN #	4 admitted to giving					
	medication to Re	esident #10 and Resident					
	#4 after they refi	used. The Administrator					
	indicated LPN #	4 was able to state the					
	facility policy or	n residents refusing					
	1	did not follow the policy					
	and was termina	1 2					
	The investigative	e report provided by the					
		1 5-23-11 at 2:30 p.m.,					
		4 was observed on 5-4-11					
		#10 medication after the					
	"	repeatedly. Resident #10					
	1	on all over his face and					
	1 -						
	1	ident #10 was "visibly					
	1 -	then made Resident #4					
	1 ^	wide and take her					
	medication after	she repeatedly said she					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M A. BUI		NSTRUCTION 00	(X3) DATE S COMPL	ETED	
		155573	B. WIN			05/26/2	011
NAME OF F	ROVIDER OR SUPPLIER		•	1	ADDRESS, CITY, STATE, ZIP CODE	•	
MILLEDIS	S MERRY MANOR				ECHWOOD AVENUE ETOWN, IN47356		
					= 1 O VVIN, 11N47 330		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	· ·	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	DATE
	did not want her	medicine. LPN #4 was					
	sent home immed						
		nding the investigation.					
	_	ministrator and Director					
	of Nursing interv	riewed LPN #4. LPN #4					
	admitted she gav	e Resident #10 and					
		ication after they refused.					
	The Administrate	or terminated LPN #4					
		N did not follow the					
	facility policy for	_					
		sidents when they refuse					
	_	dent #10 to "take his					
		e clearly refused to be					
	abusive."						
	The abuse prohib	oition, reporting and					
	•	icy provided by the					
	•	5-23-11 at 2:30 p.m.,					
		inition of abuse was "					
		verbal and or mental					
		as the willful infliction of					
	injury, unreasona	able confinement,					
	intimidation, or p	ounishment with resulting					
	harm, pain or me	ntal anguish.					
	3.1-27(a)(1)						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155573		(X2) MULTIPLI A. BUILDING B. WING	E CONSTRUCTION 00	(X3) DATE COMP 05/26/2	LETED	
	PROVIDER OR SUPPLIER		981	ET ADDRESS, CITY, STATE, ZIP COD BEECHWOOD AVENUE DLETOWN, IN47356	E	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APP DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F0279 SS=D	resident's compress The facility must do care plan for each measurable object a resident's medic psychosocial need comprehensive as The care plan must are to be furnished resident's highest mental, and psych required under §44 would otherwise be but are not provide exercise of rights or right to refuse treat Based on intervier facility failed to a plan with prevent tracheostomy tubersidents sample of 10 (Reference of the resident's diagnoral facility failed to a plan with prevent tracheostomy tubersidents sample of 10 (Reference of the resident's diagnoral facility failed to a plan with prevent tracheostomy tubersidents sample of 10 (Reference of the resident's diagnoral facility failed to, accongestive heart	velop, review and revise the hensive plan of care. evelop a comprehensive resident that includes lives and timetables to meet al, nursing, and mental and its that are identified in the sessment. St describe the services that it to attain or maintain the practicable physical, osocial well-being as 33.25; and any services that it e required under §483.25 and due to the resident's under §483.10, including the timent under §483.10(b)(4). It was and record review, the update and revise a care tive measures for a fee dislodging for 1 of 10 and for care plans in a total desident #23). Cord of Resident #23 on a.m., indicated the ses included, but were utte respiratory failure, failure, anxiety, accident (CVA) (stroke)	F0279	Resident #23 was the oresident found to be aff this deficient practice. The plan has been revised the tracheotomy collar resident #23. All licens will be in serviced on 6/2 only Portex adult trache collar will be used. This placed on the TAR for linurses to monitor that the collar is in place and the secure every shift. TAR documentation will be cusing the "Trach Collar Placement" QA tool. [Attachment#3]. This to specifically addresses: Portex adult collar only and is secure, 2) the cataddresses the approprial nurses are documentation.	ected by he care to address for ed nurses (22/11 that eotomy s has been icensed he correct at is checked 1) that is in place ire plan ate collar,	06/25/2011

000342

l i '		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155573	B. WIN	NG		05/26/20	011
NAME OF F	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
				1	ECHWOOD AVENUE		
MILLER'S	S MERRY MANOR			MIDDLE	ETOWN, IN47356		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	The Minimum D	,			this is being monitored every shift.The "Trach Collar	′	
		esident #23, dated,			Placement" QA tool will be		
	2-28-11, indicate	ed the following:			completed by the DON or		
	respiratory treatn	nents- tracheostomy care.			designee five times per weel	k for	
					four weeks, weekly for three		
	The physician's r	ecapitulation for			months and monthly thereaft	ter.	
	Resident #23, da	ted May 2011, indicated					
	tracheostomy siz	e 8, oxygen at 10 liters					
	per trachea mask	with 100 % humidity					
	and 50 PSI (press	sure).					
	· ·	,					
	The care plan for	Resident #23, dated,					
	•	d the resident had an					
	· ·	ne interventions were					
		al doctor as needed,					
		as ordered, provide					
		rdered and suction as					
		plan indicated no new					
		led after 2-16-11.					
	interventions add	ica anci 2-10-11.					
	The recident tran	sfer form for Resident					
		1 at 11:20 p.m. indicated,					
		t's room, trach completely					
		her in bed," physician					
		ew order was received to					
		to the emergency room					
		e resident's blood					
	_	7/59, pulse was 90,					
	-	24 and temperature was					
	99.1.						
		1 1 1					
	•	al History and Physical					
		, dated 4-4-11, indicated					
	the resident had a	a tracheostomy size 8 that					

000342

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

l	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155573	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE COMP 05/26/2	LETED
	PROVIDER OR SUPPLIER S MERRY MANOR		981 BE	ADDRESS, CITY, STATE, ZIP CODE ECHWOOD AVENUE ETOWN, IN47356	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)) BE	(X5) COMPLETION DATE
	amount of time. tolerating oxygen no significant red desaturations. At local hospital to tube back in but done and an size put in. Interview with the 5-24-11 at 11:25 facility did not put in attempt to pre tube from cominum to the factor of the factor o	ne Unit Manager on p.m., indicated she was				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155573 05/26/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 981 BEECHWOOD AVENUE MILLER'S MERRY MANOR MIDDLETOWN, IN47356 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE F0282 The services provided or arranged by the facility must be provided by qualified persons SS=D in accordance with each resident's written plan of care. Resident #34: Dietary F0282 06/25/2011 Based on observation, interview interventions on the health care and record review, the facility plan have been reviewed/revised failed to follow the nutritional care and the resident is receiving all items as indicated on the plan of plan for 1 of 10 residents reviewed care.All residents are at risk for for care plans in a sample of 10. being affected by this deficient practice. Each resident's dietary (Resident #34) plan of care will be reviewed by the Certified Dietary Manager or her designee by 6/25/11 to ensure Findings include: that the items included in the plan of care coordinates with what the resident is receiving on his or her On 5/24/11 at 7:30 a.m., Resident meal tray. The CDM, DON and #34 was observed eating breakfast. Unit Manager will update the care Resident #34 received 4 ounces of plan and menus weekly as interventions are implemented or 2% milk. She did not receive a revised. All nursing and dietary house shake or magic cup with her staff will be in serviced on the importance of providing specific breakfast. food items at meals in accordance with each resident's individual plan of care. The CDM On 5/24/11 at 12:15 p.m., Resident or designee will be responsible to #34's lunch did not include milk, a complete the QA tool "Meal Accuracy Audit" house shake or magic cup. [Attachement#4] on two meals a day for a total of ten days. The Resident #34's record was reviewed meals will be varied to include breakfast, lunch, and supper on 5/23/11 at 10:25 a.m. Resident throughout the ten day audit to #34's diagnoses included, but were monitor for and or to identify any systemic issues. Any identified not limited to, dementia, issues will be immediately

000342

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	155573	- 1	LDING	00	COMPL 05/26/2	
		100070	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00/20/2	011
NAME OF I	PROVIDER OR SUPPLIER			1	ECHWOOD AVENUE		
	S MERRY MANOR			1	ETOWN, IN47356		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	1	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
- Inc	1	sease, weight loss		1710	corrected and logged on to t	he	DATE
	and a history o	of dehydration.			facility's QA tracking log. Following the ten day audit,	the	
	Resident #34's 3/2/11 with a r 5/16/11, indica nutritional risk and/or fluid in will remain fre weight loss. It serve whole m increase calori serve house su	care plan dated, revision date of ated, "Focus, a related to: poor food takes. Goal, resident the from significant and the reventions, 3/2/11, ilk with meals to a c intake and 4/29/11, pplement shakes at a gic cups to increase			Following the ten day audit, QA toll titled Meal Accuracy, will be completed by the CD designee weekly on all three meals for the four weeks and then monthly thereafter. Re of the audits will be reviewed monthly during the facility's meeting to ensure ongoing compliance.	Audit M or e d sults d	
	indicated the f - 2/17/11, 107, - 3/2/11, 107.6 - 4/8/11, 105, p - 5/11/11, 101. Resident #34's Dietary (RD) A 5/24/11, indicated high risk for m Comments by	pounds pounds pounds					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO LDING	ONSTRUCTION 00	(X3) DATE S COMPL	ETED	
		155573	B. WIN			05/26/20	011
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
MILLER'S	S MERRY MANOR			1	ECHWOOD AVENUE ETOWN, IN47356		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
		t loss, (GERD)		-			
	gastroesophag	eal reflux, diabetic					
	mellitus, hyper	rtension (high blood					
	pressure), Peri	actin appetite					
	stimulant. Ab	normal labs 5/20/11					
	Weight 101.4,	diet order regular,					
	receives whole	e milk, house shake,					
	and magic cup	with meals. Weight					
	loss 3.5% time	es 30 days, 5.2%					
	times 90 days,	6.7% times 180					
	days.						
	Resident #34's	most recent "Dietary					
		ssment and MDS					
	[Minimum Da						
		ated the following:					
	·	have orders from					
	physician to re	eceive nutritional					
		vith meals or between					
	meals, no						
	- does resident	receive dietary					
	provided nutri	tional supplements					
	(e.g. house sha	ikes, house					
	supplement, no						
	_	ole with no loss or					
	gain noted the						
		re plan initiated or					
	updated, yes						
	- recommenda	tions, none, continue					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	T OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155573	A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE S COMPL 05/26/2	ETED
	ROVIDER OR SUPPLIER		•	981 BEI	.DDRESS, CITY, STATE, ZIP CODE ECHWOOD AVENUE ETOWN, IN47356		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	with current p. Interview with on 5/24/11 at 2 the Registered assessment be 5/24/11 was or assessment sho on 2/28/11. In #34 had a weighten she added the house suppression of the suppression of the house suppression. She also #34 had not be with the house suppression.	lan of nutritional care a the Dietary Manager 2:35 p.m., indicated Dietician's last fore the one on a 1/5/10 and the last be had completed was a May 2011, Resident ght loss and that was and the interventions of blement shakes and meals to the care a indicated Resident been receiving the ment shakes and			(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
		155573	B. WING			05/26/2	011
	n a v v n n a v m n v v n				ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			981 BE	ECHWOOD AVENUE		
	S MERRY MANOR				ETOWN, IN47356		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION) dent's comprehensive		TAG	DEFICIENCE)		DATE
F0315 SS=D		acility must ensure that a					
33-0		rs the facility without an					
	•	r is not catheterized unless					
		cal condition demonstrates					
		n was necessary; and a continent of bladder receives					
		ent and services to prevent					
	urinary tract infect	ions and to restore as much					
	normal bladder fur	•					
	Based on obse	rvation, interview	F0	315	All residents have the potent be affected by this deficient	iai to	06/25/2011
	and record rev	iew, the facility			practice. An inservice will be	held	
	failed to provi	de proper peri care on			on 6/22/11 by the DON for all nursing staff. The inservice will		
	1 resident with	a history of urinary		review the policy and proced			
	tract infections	s (UTI) for 1 of 3			for "Peri Care" [Attachment #5]. The policy and procedure includes pedicure and incontinent		
	residents revie	ewed for peri care in a					
	sample of 10.	(Resident #34)			care. This inservice will be g		
	1	,			annually and for all new hires		
	Findings inclu	de·			Skills check offs for perineal		
	i mamgs mera	de.			care for CNAs wail be evalua by a nurse manager or RN.		
	On 5/22/11 at	2:50 n m stoff CNIA			check off is titled "Procedure	34:	
		2:50 p.m., staff CNA			Perineal Care" [Attachment #		
	•	ing incontinence care			These check off will be comp by 6/25/11. Thereafter, the n		
		4. Staff CNA #3			manager or designee will do		
	washed both s	ides of Resident #34's			skills check offs randomly for		
	groin area and	with the same wash			weeks, monthly for four mont		
		ed Resident #34's			and then annually. The inservent and skills check offs will done		
		ing at the back and			all new hires.	3 011	
		C					
	going to the fr	OIII.					
	Description :	<i>5/</i> 22/11					
	•	ew on 5/23/11 at 3:00					
	•	A #3 indicated she					
	was nervous a	nd forgot the proper					

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155573	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE COMP 05/26/2	LETED
	PROVIDER OR SUPPLIER		981 BE	ADDRESS, CITY, STATE, ZIP CODE ECHWOOD AVENUE ETOWN, IN47356	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	.D BE	(X5) COMPLETION DATE
PREFIX	Resident #34's on 5/23/11 at #34's diagnose not limited to, urinary incont frequency. Resident #34's dated, 3/28/11 "Macrobid (ar (milligrams), I day, for 10 day Resident #34's dated, 4/10/11	performing peri care. s record was reviewed 10:25 a.m. Resident es included, but were repeated UTIs, inence and urinary s physician's order , indicated, atibiotic) 100 mg by mouth, two times a ys related to UTI." s physician's order , indicated "Macrobid outh, two times a day,	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR	.D BE	COMPLETION

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTII	PLE CON	STRUCTION	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G	00	COMPL	ETED	
		155573	B. WING	J		05/26/2	011	
NAMEOFI	DDOLUDED OD GLIDDLIED			REET AD	DRESS, CITY, STATE, ZIP CODE			
NAME OF F	PROVIDER OR SUPPLIER		98	31 BEE	CHWOOD AVENUE			
MILLER'S	S MERRY MANOR		M	IDDLET	ΓΟWN, IN47356			
(X4) ID		TATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT			(X5)		
PREFIX TAG	•	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	TA		CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION DATE	
F0325 SS=D	assessment, the fresident - (1) Maintains accernutritional status, sprotein levels, unlecondition demonstrates and (2) Receives a the anutritional proble Based on observand record reversided to follow for preventing further weight residents revier in a sample of Findings inclusion of the findings in the findings inclusion of the findings in	ervation, interview riew, the facility w and revise a plan weight loss or any loss for 1 of 2 ewed for weight loss 110. (Resident #34)	F0325		Resident #34: Dietary interventions on the health caplan have been reviewed/rev and the resident is receiving items as indicated on the plan care. All residents are at risk to being affected by this deficien practice. Each resident's dietar plan of care will be reviewed the CDM or her designee by 6/25/11 to ensure that the iterincluded in the plan of care coordinates with what the resident is receiving on his or meal tray. The CDM, DON a Unit Manager will update the care plan and menus weekly interventions are implementer revised. All nursing and dietarstaff will be in serviced on the importance of providing spections are meals in accordance with each resident	rised all n of for nt ary by ms r her and e as d or ary e diffic	06/25/2011	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	NSTRUCTION	(X3) DATE SU		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLE	
		155573	B. WIN			05/26/20	11
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
MILLEDIA				1	ECHWOOD AVENUE		
	S MERRY MANOR			INIIDDLI	ETOWN, IN47356		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT	re	COMPLETION DATE
IAG	REGULATORT OR	ESC IDENTIF TING INFORMATION)		IAG	individual plan of care.The C	DM	DAIL
	0 7/04/44				or designee will be responsit		
	On 5/24/11 at	12:15 p.m., Resident			complete the QA tool "Meal		
	#34's lunch did	d not include milk, a			Accuracy Audit" [Attachment		
	house shake or	magic cup.			#4] on two meals a day for a of ten days. The meals will be		
					varied to include breakfast, li		
	Resident #34's	record was reviewed			and supper throughout the te	en	
	on 5/23/11 at 1	0:25 a.m. Resident			day audit to monitor for and or identify any systemic issues.		
	#34's diagnose	s included, but were			identified issues will be		
	not limited to,	dementia.			immediately corrected and lo on to the facility's QA tracking		
	<u> </u>	sease, weight loss			log. Following the ten day a	~ 1	
	and a history of	, •			the QA toll titled "Meal Accur		
		deliyaration.			Audit" [Attachment #4] will be completed by the CDM or	9	
	D: 1 4 #2 41-				designee weekly on all three		
		care plan dated			meals for the four weeks and		
		revision date of			then monthly thereafter. Res		
	5/16/11, indica	ited, "Focus,			monthly during the facility's (
	nutritional risk	related to: poor food			meeting to ensure ongoing		
	and/or fluid in	takes. Goal, resident			compliance.		
	will remain fre	e from significant					
		nterventions, 3/2/11,					
	_	ilk with meals to					
		c intake and 4/29/11,					
		· · · · · · · · · · · · · · · · · · ·					
		pplement shakes at					
	~	gic cups to increase					
	caloric intake.	1					
	Resident #34's	"weight record"					
	indicated the following:						
	- 2/17/11, 107,						
	- 3/2/11, 107.6	-					
	5,2,11,107.0	Poditab					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155573			Ì	LDING	NSTRUCTION 00	(X3) DATE : COMPL 05/26/2	ETED
	PROVIDER OR SUPPLIER			981 BEI	DDRESS, CITY, STATE, ZIP CODE ECHWOOD AVENUE ETOWN, IN47356		
(X4) ID PREFIX	SUMMARY S	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	- 4/8/11, 105, j - 5/11/11, 101						
		s "Dietary Registered					
		Assessment, dated ated Resident #34 at					
	· ·	utritional problems.					
	•	the RD indicated,					
		Disease, weight loss, oesophageal reflux,					
	· / •	us, hypertension					
		essure), Periactin					
		lant. Abnormal labs ght 101.4, diet order					
		res whole milk, house					
	ŕ	gic cup with meals.					
	_	5% times 30 days,					
	180 days."	days, 6.7% times					
		s most recent "Dietary					
	_	ssment and MDS,"					
	dated 2/28/11, following:	indicated the					
	_	t have orders from					
		eceive nutritional					
		with meals or between					
	meals, no - does resident	t receive dietary					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155573		(X2) M A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE : COMPL 05/26/2	ETED	
	PROVIDER OR SUPPLIER	2	•	981 BEI	DDRESS, CITY, STATE, ZIP CODE ECHWOOD AVENUE ETOWN, IN47356		
MILLER' (X4) ID PREFIX TAG	regulatory or provided nutri (e.g. house sha supplement, n - weight is sta gain noted the - nutritional ca updated, yes - recommenda with current p	o ble with no loss or		1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	on 5/24/11 at 2 the Registered assessment be 5/24/11 was o assessment sh on 2/28/11. Ir #34 had a wei when she adde the house supp magic cups at plan. She also #34 had not be	2:35 p.m., indicated Dietician's last fore the one on 1/5/10 and the last e had completed was May 2011, Resident ght loss and that was ed the interventions of clement shakes and meals to the care o indicated Resident een receiving the ment shakes and					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155573		ĺ	LDING	ONSTRUCTION 00	(X3) DATE COMPL	ETED	
	ROVIDER OR SUPPLIER			981 BE	ADDRESS, CITY, STATE, ZIP CODE ECHWOOD AVENUE ETOWN, IN47356	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΛΤΕ	(X5) COMPLETION DATE
F0328 SS=D	proper treatment a special services: Injections; Parenteral and en Colostomy, ureter Tracheostomy car Tracheal suctionin Respiratory care; Foot care; and Prostheses. Based on obse and record rev failed to invest tracheostomy the neck throup provide an air and failed to p to prevent it from a resident with that dislodged sampled for tracheostomy the sample of the color of the col	rvation, interview iew, the facility tigate the cause of a tube (an opening in gh the trachea to way) coming out, ut measures in place om coming out again with a tracheostomy for 1 of 1 resident acheostomy care in a f 10 (Resident #23).	FO	0328	Resident #23 was the only resident found to be affected this deficient practice. The caplan has been revised to ad the tracheotomy collar for resident #23. All licensed n will be in serviced on 6/22/1 only Portex adult tracheotom collar will be used. This has placed on the TAR for licens nurses to monitor that the cacollar is in place and that is secure every shift. TAR documentation will be check using the "Trach Collar Placement" QA tool. [Attach #3]. This tool specifically addresses: 1) that Portex a collar only is in place and is secure, 2) the care plan addresses the appropriate of 3) nurses are documenting this is being monitored ever	are dress urses 1 that ny s been sed prrect ared ment dult collar, that	06/25/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND FLAN	OF CORRECTION	155573	A. BUI		00	05/26/2011	
			B. WIN	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				ECHWOOD AVENUE		
MILLER'S	S MERRY MANOR			MIDDLE	ETOWN, IN47356		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	,
PREFIX TAG	· ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E COMPLETION DATE	١
	#23 on 5-23-1						
	indicated the r			Placement" [Attachment #3] tool will be completed by the	•		
		were not limited to,			or designee five times per we		
	acute respiratory failure, congestive heart failure, anxiety,				for four weeks, weekly for the	•	
					months and monthly thereaft	ei.	
	· ·	ar accident (CVA)					
	(stroke) and at	` /					
	tracheostomy.						
	The Minimum	Data Set (MDS)					
		Resident #23, dated					
		ated the following:					
	ability to unde						
	understands, n						
	l '	sually understood,					
		dependence of two					
		n room- did not					
		l hygiene- total					
	_	two people, bed					
	_	dependence of two					
	people and res	piratory treatments-					
	tracheostomy	• •					
	The physician	recapitulation for					
	Resident #23,	dated May 2011,					
	indicated trach	neostomy size 8,					
	oxygen at 10 l	iters per trachea mask					
		midity and 50 PSI					
	(pressure).						
	l						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155573	LDING	NSTRUCTION 00	(X3) DATE S COMPL 05/26/20	ETED
NAME OF I	PROVIDER OR SUPPLIER	<u> </u>	 STREET A	ADDRESS, CITY, STATE, ZIP CODE		
MILLER'	S MERRY MANOR			ECHWOOD AVENUE ETOWN, IN47356		
(X4) ID		STATEMENT OF DEFICIENCIES	 ID			(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
	dated 2-16-11 resident had a	for Resident #23, indicated the tracheostomy. The were to notify the				
		•				
		r as needed, provide ered, provide trachea				
	1	d and suction as				
	needed.	a and saction as				
	The resident to	ransfer form for				
	Resident #23,	dated 4-3-11 at 11:20				
	p.m., indicated	d, "Entered resident's				
	room, trach co	ompletely out laying				
	next to her in	bed," physician				
	notified and a	n new order was				
	received to se	nd the resident to the				
		om for treatment. The				
		od pressure was				
	l '-	was 90, respirations				
	were 24 and to	emperature was 99.1.				
	The least have	sital Higtory and				
	1	oital History and				
	1 -	esident #23, dated ted the resident had a				
		tube size 8 that came				
	·	lity for an unknown				
		e. The resident was				
	l	gen by a mask and				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155573		(X2) MU A. BUIL B. WING	LDING	NSTRUCTION 00	(X3) DATE COMPL 05/26/2	LETED	
	PROVIDER OR SUPPLIER			981 BE	ADDRESS, CITY, STATE, ZIP CODE ECHWOOD AVENUE ETOWN, IN47356		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	distress or des were made by put a size 8 train but this was and a size 4 traput in. During observed 3:20 p.m., Resin bed with a the liters of oxyget and 50 psi. The collar attached neck and velocity tracheostomy. Interview with 5-24-11 at 11:25 facility did not on how Reside tracheostomy. Unit Manager did not put any attempt to preventive from control Unit Manager sure of the causes.	a the Unit Manager on 25 a.m., indicated the do an investigation ent #23's tube came out. The indicated the facility measures in place in vent the tracheostomy sing out again. The indicated she was not					

STREET ADDRESS, CITY, STATE_UP CODE	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				INSTRUCTION 00	(X3) DATE S COMPL		
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR MIDDLETOWN, IN 17356 SIRRET ADDRESS, CITY, STATE, ZIP CODE 981 BEECHWOOD AVENUE MIDDLETOWN, IN 17356 SIRRET ADDRESS, CITY, STATE, ZIP CODE 981 BEECHWOOD AVENUE MIDDLETOWN, IN 17356 CXS) IN 17356 IN			155573				05/26/2	011
MILLER'S MERRY MANOR (X4) ID SUMMARY STATEMENT OF DEPICENCES PREFIX (12ACH DEPICENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) Interview with the Unit Manager on 5-24-11 at 12:10 p.m., indicated she was unable to find any additional documentation on the incident with Resident #23's tracheostomy tube dislodging. Interview with LPN #1 on 5-25-11 at 9:30 a.m., indicated she was the nurse carring for Resident #23 when the resident's tracheostomy tube dislodged. LPN #1 indicated she had just come on duty, had got report and counted medication when an CNA came and told her Resident #23 needs you. LPN #1 indicated when she went into Resident #23's bedroom her tracheostomy tube was out and lying on her right shoulder, the collar was still attached. LPN #1 indicated the resident was not secured on the left side and the right side of the collar was still attached. LPN #1 indicated the resident was not in any respiratory distress and was talking with her. LPN #1 indicated she did oxygen saturations on the resident	NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
SUMMARY STATEMENT OF DEFICIENCIES 1D PROPRIET PREFIX (LEACH DEFICIENCY MUST BE PERCEDED BY FULL TAG PREFIX (LEACH DEFICIENCY MUST BE PERCEDED BY FULL TAG PREFIX PREFIX PROPRIETION COMPLETION DATE Interview with the Unit Manager on 5-24-11 at 12:10 p.m., indicated she was unable to find any additional documentation on the incident with Resident #23's tracheostomy tube dislodging. Interview with LPN #1 on 5-25-11 at 9:30 a.m., indicated she was the nurse caring for Resident #23 when the resident's tracheostomy tube dislodged. LPN #1 indicated she had just come on duty, had got report and counted medication when an CNA came and told her Resident #23 needs you. LPN #1 indicated when she went into Resident #23's bedroom her tracheostomy tube was out and lying on her right shoulder, the collar was not secured on the left side and the right side of the collar was still attached. LPN #1 indicated the respiratory distress and was talking with her. LPN #1 indicated she did oxygen saturations on the resident					1			
Interview with the Unit Manager on 5-24-11 at 12:10 p.m., indicated she was unable to find any additional documentation on the incident with Resident #23's tracheostomy tube dislodging. Interview with LPN #1 on 5-25-11 at 9:30 a.m., indicated she was the nurse caring for Resident #23 when the resident's tracheostomy tube dislodged. LPN #1 indicated she had just come on duty, had got report and counted medication when an CNA came and told her Resident #23's bedroom her tracheostomy tube was out and lying on her right shoulder, the collar was still attached. LPN #1 indicated the resident was not in any respiratory distress and was talking with her. LPN #1 indicated she did oxygen saturations on the resident			TATEMENT OF DEPLOIPNOISE			= 1 OVVIN, 11N47 330		(7/5)
Interview with the Unit Manager on 5-24-11 at 12:10 p.m., indicated she was unable to find any additional documentation on the incident with Resident #23's tracheostomy tube dislodging. Interview with LPN #1 on 5-25-11 at 9:30 a.m., indicated she was the nurse caring for Resident #23 when the resident's tracheostomy tube dislodged. LPN #1 indicated she had just come on duty, had got report and counted medication when an CNA came and told her Resident #23 needs you. LPN #1 indicated when she went into Resident #23's bedroom her tracheostomy tube was out and lying on her right shoulder, the collar was not secured on the left side and the right side of the collar was still attached. LPN #1 indicated the resident was not in any respiratory distress and was talking with her. LPN #1 indicated she did oxygen saturations on the resident					PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION	
5-24-11 at 12:10 p.m., indicated she was unable to find any additional documentation on the incident with Resident #23's tracheostomy tube dislodging. Interview with LPN #1 on 5-25-11 at 9:30 a.m., indicated she was the nurse caring for Resident #23 when the resident's tracheostomy tube dislodged. LPN #1 indicated she had just come on duty, had got report and counted medication when an CNA came and told her Resident #23 needs you. LPN #1 indicated when she went into Resident #23's bedroom her tracheostomy tube was out and lying on her right shoulder, the collar was not secured on the left side and the right side of the collar was still attached. LPN #1 indicated the resident was not in any respiratory distress and was talking with her. LPN #1 indicated she did oxygen saturations on the resident	TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	<u> </u>	TAG		I E	DATE
5-24-11 at 12:10 p.m., indicated she was unable to find any additional documentation on the incident with Resident #23's tracheostomy tube dislodging. Interview with LPN #1 on 5-25-11 at 9:30 a.m., indicated she was the nurse caring for Resident #23 when the resident's tracheostomy tube dislodged. LPN #1 indicated she had just come on duty, had got report and counted medication when an CNA came and told her Resident #23 needs you. LPN #1 indicated when she went into Resident #23's bedroom her tracheostomy tube was out and lying on her right shoulder, the collar was not secured on the left side and the right side of the collar was still attached. LPN #1 indicated the resident was not in any respiratory distress and was talking with her. LPN #1 indicated she did oxygen saturations on the resident								
was unable to find any additional documentation on the incident with Resident #23's tracheostomy tube dislodging. Interview with LPN #1 on 5-25-11 at 9:30 a.m., indicated she was the nurse caring for Resident #23 when the resident's tracheostomy tube dislodged. LPN #1 indicated she had just come on duty, had got report and counted medication when an CNA came and told her Resident #23 needs you. LPN #1 indicated when she went into Resident #23's bedroom her tracheostomy tube was out and lying on her right shoulder, the collar was not secured on the left side and the right side of the collar was still attached. LPN #1 indicated the resident was not in any respiratory distress and was talking with her. LPN #1 indicated she did oxygen saturations on the resident		Interview with	the Unit Manager on					
documentation on the incident with Resident #23's tracheostomy tube dislodging. Interview with LPN #1 on 5-25-11 at 9:30 a.m., indicated she was the nurse caring for Resident #23 when the resident's tracheostomy tube dislodged. LPN #1 indicated she had just come on duty, had got report and counted medication when an CNA came and told her Resident #23 needs you. LPN #1 indicated when she went into Resident #23's bedroom her tracheostomy tube was out and lying on her right shoulder, the collar was not secured on the left side and the right side of the collar was still attached. LPN #1 indicated the resident was not in any respiratory distress and was talking with her. LPN #1 indicated she did oxygen saturations on the resident		5-24-11 at 12:	10 p.m., indicated she					
Resident #23's tracheostomy tube dislodging. Interview with LPN #1 on 5-25-11 at 9:30 a.m., indicated she was the nurse caring for Resident #23 when the resident's tracheostomy tube dislodged. LPN #1 indicated she had just come on duty, had got report and counted medication when an CNA came and told her Resident #23 needs you. LPN #1 indicated when she went into Resident #23's bedroom her tracheostomy tube was out and lying on her right shoulder, the collar was not secured on the left side and the right side of the collar was still attached. LPN #1 indicated the resident was not in any respiratory distress and was talking with her. LPN #1 indicated she did oxygen saturations on the resident		was unable to	find any additional					
dislodging. Interview with LPN #1 on 5-25-11 at 9:30 a.m., indicated she was the nurse caring for Resident #23 when the resident's tracheostomy tube dislodged. LPN #1 indicated she had just come on duty, had got report and counted medication when an CNA came and told her Resident #23 needs you. LPN #1 indicated when she went into Resident #23's bedroom her tracheostomy tube was out and lying on her right shoulder, the collar was not secured on the left side and the right side of the collar was still attached. LPN #1 indicated the resident was not in any respiratory distress and was talking with her. LPN #1 indicated she did oxygen saturations on the resident		documentation	on the incident with					
Interview with LPN #1 on 5-25-11 at 9:30 a.m., indicated she was the nurse caring for Resident #23 when the resident's tracheostomy tube dislodged. LPN #1 indicated she had just come on duty, had got report and counted medication when an CNA came and told her Resident #23 needs you. LPN #1 indicated when she went into Resident #23's bedroom her tracheostomy tube was out and lying on her right shoulder, the collar was not secured on the left side and the right side of the collar was still attached. LPN #1 indicated the resident was not in any respiratory distress and was talking with her. LPN #1 indicated she did oxygen saturations on the resident		Resident #23's	tracheostomy tube					
at 9:30 a.m., indicated she was the nurse caring for Resident #23 when the resident's tracheostomy tube dislodged. LPN #1 indicated she had just come on duty, had got report and counted medication when an CNA came and told her Resident #23 needs you. LPN #1 indicated when she went into Resident #23's bedroom her tracheostomy tube was out and lying on her right shoulder, the collar was not secured on the left side and the right side of the collar was still attached. LPN #1 indicated the resident was not in any respiratory distress and was talking with her. LPN #1 indicated she did oxygen saturations on the resident		dislodging.						
at 9:30 a.m., indicated she was the nurse caring for Resident #23 when the resident's tracheostomy tube dislodged. LPN #1 indicated she had just come on duty, had got report and counted medication when an CNA came and told her Resident #23 needs you. LPN #1 indicated when she went into Resident #23's bedroom her tracheostomy tube was out and lying on her right shoulder, the collar was not secured on the left side and the right side of the collar was still attached. LPN #1 indicated the resident was not in any respiratory distress and was talking with her. LPN #1 indicated she did oxygen saturations on the resident								
nurse caring for Resident #23 when the resident's tracheostomy tube dislodged. LPN #1 indicated she had just come on duty, had got report and counted medication when an CNA came and told her Resident #23 needs you. LPN #1 indicated when she went into Resident #23's bedroom her tracheostomy tube was out and lying on her right shoulder, the collar was not secured on the left side and the right side of the collar was still attached. LPN #1 indicated the resident was not in any respiratory distress and was talking with her. LPN #1 indicated she did oxygen saturations on the resident		Interview with	LPN #1 on 5-25-11					
the resident's tracheostomy tube dislodged. LPN #1 indicated she had just come on duty, had got report and counted medication when an CNA came and told her Resident #23 needs you. LPN #1 indicated when she went into Resident #23's bedroom her tracheostomy tube was out and lying on her right shoulder, the collar was not secured on the left side and the right side of the collar was still attached. LPN #1 indicated the resident was not in any respiratory distress and was talking with her. LPN #1 indicated she did oxygen saturations on the resident		at 9:30 a.m., ir	ndicated she was the					
dislodged. LPN #1 indicated she had just come on duty, had got report and counted medication when an CNA came and told her Resident #23 needs you. LPN #1 indicated when she went into Resident #23's bedroom her tracheostomy tube was out and lying on her right shoulder, the collar was not secured on the left side and the right side of the collar was still attached. LPN #1 indicated the resident was not in any respiratory distress and was talking with her. LPN #1 indicated she did oxygen saturations on the resident		nurse caring fo	or Resident #23 when					
had just come on duty, had got report and counted medication when an CNA came and told her Resident #23 needs you. LPN #1 indicated when she went into Resident #23's bedroom her tracheostomy tube was out and lying on her right shoulder, the collar was not secured on the left side and the right side of the collar was still attached. LPN #1 indicated the resident was not in any respiratory distress and was talking with her. LPN #1 indicated she did oxygen saturations on the resident		the resident's t	racheostomy tube					
report and counted medication when an CNA came and told her Resident #23 needs you. LPN #1 indicated when she went into Resident #23's bedroom her tracheostomy tube was out and lying on her right shoulder, the collar was not secured on the left side and the right side of the collar was still attached. LPN #1 indicated the resident was not in any respiratory distress and was talking with her. LPN #1 indicated she did oxygen saturations on the resident		dislodged. LP1	N #1 indicated she					
when an CNA came and told her Resident #23 needs you. LPN #1 indicated when she went into Resident #23's bedroom her tracheostomy tube was out and lying on her right shoulder, the collar was not secured on the left side and the right side of the collar was still attached. LPN #1 indicated the resident was not in any respiratory distress and was talking with her. LPN #1 indicated she did oxygen saturations on the resident		had just come	on duty, had got					
Resident #23 needs you. LPN #1 indicated when she went into Resident #23's bedroom her tracheostomy tube was out and lying on her right shoulder, the collar was not secured on the left side and the right side of the collar was still attached. LPN #1 indicated the resident was not in any respiratory distress and was talking with her. LPN #1 indicated she did oxygen saturations on the resident		report and cou	nted medication					
indicated when she went into Resident #23's bedroom her tracheostomy tube was out and lying on her right shoulder, the collar was not secured on the left side and the right side of the collar was still attached. LPN #1 indicated the resident was not in any respiratory distress and was talking with her. LPN #1 indicated she did oxygen saturations on the resident		when an CNA	came and told her					
Resident #23's bedroom her tracheostomy tube was out and lying on her right shoulder, the collar was not secured on the left side and the right side of the collar was still attached. LPN #1 indicated the resident was not in any respiratory distress and was talking with her. LPN #1 indicated she did oxygen saturations on the resident		Resident #23 r	needs you. LPN #1					
tracheostomy tube was out and lying on her right shoulder, the collar was not secured on the left side and the right side of the collar was still attached. LPN #1 indicated the resident was not in any respiratory distress and was talking with her. LPN #1 indicated she did oxygen saturations on the resident		indicated when	n she went into					
lying on her right shoulder, the collar was not secured on the left side and the right side of the collar was still attached. LPN #1 indicated the resident was not in any respiratory distress and was talking with her. LPN #1 indicated she did oxygen saturations on the resident		Resident #23's	bedroom her					
collar was not secured on the left side and the right side of the collar was still attached. LPN #1 indicated the resident was not in any respiratory distress and was talking with her. LPN #1 indicated she did oxygen saturations on the resident		tracheostomy t	tube was out and					
side and the right side of the collar was still attached. LPN #1 indicated the resident was not in any respiratory distress and was talking with her. LPN #1 indicated she did oxygen saturations on the resident		lying on her ri	ght shoulder, the					
was still attached. LPN #1 indicated the resident was not in any respiratory distress and was talking with her. LPN #1 indicated she did oxygen saturations on the resident		collar was not	secured on the left					
the resident was not in any respiratory distress and was talking with her. LPN #1 indicated she did oxygen saturations on the resident		side and the rig	ght side of the collar					
respiratory distress and was talking with her. LPN #1 indicated she did oxygen saturations on the resident		was still attach	ned. LPN #1 indicated					
with her. LPN #1 indicated she did oxygen saturations on the resident		the resident wa	as not in any					
oxygen saturations on the resident			_					
		with her. LPN	#1 indicated she did					
twice and thought the first one was		oxygen saturat	ions on the resident					
		twice and thou	ght the first one was					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155573				LDING	NSTRUCTION 00	(X3) DATE COMPL	ETED
	PROVIDER OR SUPPLIER		•	981 BEE	DDRESS, CITY, STATE, ZIP CODE ECHWOOD AVENUE ETOWN, IN47356	•	
(X4) ID PREFIX	SUMMARY S (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
PREFIX TAG	91%, but could remember. LP did know that level never we indicated she at the tracheostor unable to get it indicated she pliters by a mass stoma. LPN # another nurse and called the physician gave resident to the LPN #1 indicated the 911 service LPN #1 indicated stab the resident talentire time and she had been a realize the traccome out.	d not exactly N #1 indicated she the resident's oxygen ent down. LPN #1 attempted to reinsert my tube but was t back in. LPN #1 colaced oxygen 10 six over the resident's l indicated she had stay with the resident physician and the e an order to send the e mergency room. ated she then called e for an ambulance. ated the resident le. LPN #1 indicated liked with her the d indicated to her that asleep and didn't cheostomy tube had a Resident #23's er on 5-25-11 at 11:00		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION DATE
	out before. Th	e family member					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155573		A. BUILI B. WING	DING	00	COMPL 05/26/2	ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 981 BEECHWOOD AVENUE MIDDLETOWN, IN47356					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	I I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAL DEFICIENCY)	ΤE	(X5) COMPLETION DATE	
	indicated Resistshe didn't know and she didn't out. Interview with 5-25-11 at 2:33 resident wore awith velcro on Interview with 5-25-11 at 2:40 did not remember tracheostor Resident #23 v	dent #23 told her that w how it happened realize it had come the Unit Manager on 5 p.m., indicated the an adult size collar						

		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155573	(X2) MU A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE S COMPL 05/26/2	ETED
	PROVIDER OR SUPPLIER		1	STREET A	DDRESS, CITY, STATE, ZIP CODE ECHWOOD AVENUE ETOWN, IN47356		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
F0514 SS=D	each resident in accordessional stand complete; accurate accessible; and sy. The clinical record information to identhe resident's asseand services provipreadmission screeds and services provipreadmission screeds and progreed Based on intervious facility failed to the health status and resident's trached 1 of 10 residents documentation in (Resident #23). Finding includes Review of the resident's diagnorm of limited to, accongestive heart cerebrovascular and attention to the Minimum Diassessment for R 2-28-11, indicate respiratory treatments.	ew and record review, the document a resident's assessment after the estomy tube dislodged for sampled for a total sample of 10 cord of Resident #23 on a.m., indicated the ses included, but were ute respiratory failure, failure, anxiety, accident (CVA) (stroke) racheostomy. ata Set (MDS) esident #23, dated	F0	514	All residents have the potentibe affected by this deficient practice. All nursing staff will inservice on 6/22/11 by the E on "Charting Procedure" [Attachment #7]. Which includocumenting an assessment progress note for any change condition. The 24-hour board be updated as the changes occur. The 24 hour board will monitored Monday thru Fridathe DON or nurse managers daily nurse managers' meetir ensure all entries on the 24 hoard including progress not and assessments are carried over to the medical record. The process will be monitored at daily nurse managers' meetir by using the QA tool "Pertine Charting Review" [Attachment #8]. Results of audits will be reviewed at the facility's QA meeting to ensure continued compliance. They be reviewed monthly for four months, then quarterly for the times.	be DON udes or e in d will be ny by at the ng to nours es the ng the ng to the ng the	06/25/2011

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: LYYY11 Facility ID:

000342

If continuation sheet Page 25 of 28

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì	(X2) MULTIPLE CONSTRUCTION (X3) DATE COMP A. BUILDING O (X3) DATE		ETED	
		155573	B. WIN			05/26/2	011
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE		
MILLER'S MERRY MANOR			981 BEECHWOOD AVENUE MIDDLETOWN, IN47356				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	OF CORRECTION	
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)		DATE
	#23, dated May 2011, indicated tracheostomy size 8, oxygen at 10 liters						
	per trachea mask with 100 % humidity						
	and 50 PSI (pressure).						
	_	r Resident #23, dated					
		ed the resident had an					
	tracheostomy. The interventions were notify the medical doctor as needed, provide oxygen as ordered, provide						
	trachea care as ordered and suction as needed. The resident transfer form for Resident #23, dated 4-3-11 at 11:20 p.m. indicated,						
		_					
	"Entered resident's room, trach completely out lying next to her in bed," physician						
	, , ,						
	notified and an new order was received to send the resident to the emergency room						
	for treatment. The resident's blood pressure was 107/59, pulse was 90, respirations were 24 and temperature was						
	99.1. The documentation did not indicate						
		t or the resident's status.					
	a run assessinen	t of the resident's status.					
	Interview with the	ne Unit Manager on					
		p.m., indicated she was					
	unable to find an	-					
		on the incident with					
		acheostomy tube					
	dislodging.	,					
	Interview with LPN #1 on 5-25-11 at 9:30						
	a.m., indicated s	he was the nurse caring					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/21/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155573		LDING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/26/2011	
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER					ECHWOOD AVENUE		
MILLER'S MERRY MANOR				MIDDLE	ETOWN, IN47356		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	re C	OMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		-	IAG	DIA (CLINCT)	-	DATE
	for Resident #23 when the resident's						
	tracheostomy tube dislodged. LPN #1						
	indicated she had just come on duty, had						
	gotten report and counted medication						
	when a CNA came and told her Resident #23 needs you. LPN #1 indicated when she went into Resident #23's bedroom her						
		be was out and lying on					
	1						
	her right shoulder, the collar was not						
	secured on the left side and the right side of the collar was still attached. LPN #1						
	indicated the resident was not in any						
		ess and was talking with					
		icated she did oxygen					
		e resident twice and					
		one was 91%, but could					
	_	ember. LPN #1 indicated					
		at the resident's oxygen					
		down. LPN #1 indicated					
	she attempted to reinsert the tracheostomy tube but was unable to get it back in. LPN						
		placed oxygen 10 liters					
		he resident's stoma. LPN					
	1 -	had another nurse stay					
		and called the physician					
		n gave an order to send					
		e emergency room. LPN					
		then called the 911					
		ibulance. LPN #1					
		ident remained stable.					
		d the resident talked with					
		ne and indicated to her					
	that she had been asleep and didn't realize the tracheostomy tube had come out.						
		, , , ,					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: LYYY11 Facility ID:

000342

If continuation sheet Page 27 of 28

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155573		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		COMP	(X3) DATE SURVEY COMPLETED 05/26/2011		
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 981 BEECHWOOD AVENUE MIDDLETOWN, IN47356				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ECTION JULD BE PROPRIATE	(X5) COMPLETION DATE	
	3.1-50(a)(1)						